DOCUMENT RESUME

ED 252 011 EC 171 167

AUTHOR Marchetti, Allen
TITLE National Trends Related to Staffing Residential Facilities for the Mentally Retarded: Are More Staff the Answer?
PUB DATE May 84
NOTE 28p.; Paper presented at the Annual Meeting of the American Association on Mental Deficiency (108th, Minneapolis, MN, May 27-31, 1984).
PUB TYPE Speeches/Conference Papers (150) -- Viewpoints (120)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Cost Effectiveness; Institutional Personnel; Institutions; *Mental Retardation; *Residential Institutions; *Staff Role; *Staff Utilization; Standards; *Trend Analysis
IDENTIFIERS *Staffing Ratio

ABSTRACT

Issues related to altering organizational and staffing patterns to respond to changes in public residential facilities for mentally retarded persons are reviewed. Factors affecting societal concern for the treatment and care of mentally retarded persons are considered, including public exposes, court litigation, and the development of parental and professional advocacy groups. The changing population in facilities for mentally retarded persons is noted, and the status of staffing standards (specifically as developed by the American Association of Hospitals, and the Accreditation Council for Services for Mentally Retarded and other Developmentally Disabled persons) is reviewed. Staffing standards advanced by regulatory agencies and the courts are also described. Increases in staff-to resident ratios for a variety of medical, educational, and therapy personnel are recounted. Studies on factors affecting staff-to-resident interactions and in turn the quality of care provided are described. The paper notes that few empirical studies validating the cost/benefit relationship regarding increases in staffing ratios have been performed. (CL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

ED252011

Presentation

to

American Association on Mental Deficiency

108th Annual Meeting

National Trends Related to Staffing Residential Facilities For The Mentally Retarded: Are More Staff The Answer?

Allen Marchetti, Ph.D.

Alabama Department of Mental Health
P. O. Box 3710
Montgomery, Alabama 36193

EC171167

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Allen Marchetti
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

It is of significance that a program which examines National Trends Relating to Staffing Residential Facilities for Mentally Retarded Persons and questions "if more staff are indeed the answer to many of our administrative concerns", be addressed at this, the 108th Annual Meeting of AAMD. AAMD has been at the forefront of establishing and promulgating standards for public residential facilities for mentally retarded persons. In fact, AAMD first published a report of a special committee on standards for institutions serving mentally retarded persons in 1952, entitled the Standards Brochure, and published in 1964 a manual entitled, Standards For State Residential Institutions For The Mentally Retarded. Staffing patterns were an intricate part of these standards. These standards have had a significant bearing on the development of voluntary, regulatory, and mandated standards which were

to be drafted in the years following 1952.

Since the initial drafting of the Standards Brochure, public awareness of the plight of the mentally retarded in these facilities has resulted in a significant change in social policy. This finding has substantially effected the type and level of care mentally retarded persons are provided, the size and location of the facilities in which the mentally retarded reside, and the amount allocated for their care and treatment. All of these factors have promoted changes in both staffing and organizational patterns.

In spite of these trends, issues related to altering organizational and staffing patterns to respond to changes in public residential facilities for mentally retarded persons has received only limited attention in the general research literature.

To understand current trends with regard to staffing and organi-

zational patterns, we must first consider the antecedent conditions which effected these changes. After two decades of emphasis by the general public on improved and more humane treatment and care for the mentally retarded, public sentiment is again changing. Presently there appears to be an emphasis on curtailing services, appropriations, and placement of the more severely impaired into the community. As per diems have continued to increase to a national average of over 30,000 year as reported in 1983, the general public has become more vocal concerning the adequacy of treatment and care received by the mentally retarded, and the facilities in which they reside.

All of these factors will continue to result in increased pressure to maintain acceptable staffing ratios and effect better utilization of existing staff. Additionally, these same factors will lead to closer scrutiny of existing staffing patterns to ensure lower administrative

and support costs while at the same time increasing direct care staff-to-resident ratios.

During the mid 1960's, a number of factors significantly effected societal concern for the treatment and care of the mentally retarded. These factors included public exposes, court litigation, and the development of parental and professional advocacy groups concerned with the rights of the mentally retarded. This resulted in increased allocations for the care and treatment of the mentally retarded, improved staff-to-resident ratios, and a change in philosophy regarding the level and type of services to be provided. Emphasis on normalization and the use of the developmental model replaced the previously emphasized custodial model which was prevalent in public residential facilities prior to the late 1960's.

Emphasis on community placement for the majority of the mentally

retarded in the "least restrictive" setting was to drastically alter the composition of the residential population served by these facilities. Primarily, severely and profoundly mentally retarded individuals were to remain institutionalized, which required higher staff-to-resident ratios for their care and treatment. In the early forecasts of these ratios, the client population significantly differed from the population currently residing in these facilities. In 1965 approximately 27% of the client population in these facilities were profoundly mentally retarded as compared to 55% in 1981. As Lakin indicated, "as the relative ability of residents to provide independently for themselves decreases, direct-care demands intensify and staff time per resident increases."

From 1950 to 1967 the number of residents in public residential facilities for the mentally retarded showed a sharp increase from

approximately 128,000 individuals to 193,188 and showed a slight but progressive decline to 181,058 in 1971. This was followed by a sharp decline in the residential population to 119,335 as recently reported, or approximately 37%. The number of residents served in each facility also significantly decreased. In 1981, 34% of public residential facilities housed more than 500 residents as compared to 79% in 1962. The annual maintenance cost per resident also markedly increased. These costs show a pronounced acceleration in 1965. Annual costs increased by $23,365 per resident from 1965 to 1981, which represents more than a 600% increase in expenditures per client over a 16 year period.

Although the above mentioned factors results in significantly improved staffing ratios, there still remains controversy in the field regarding what constitutes minimally acceptable staffing ratios and if

such ratios should be promulgated at all or left to the professional judgment of those who are charged with administration of these facilities.

Specified staffing standards and ratios have been promulgated primarily from three sources. Initially, professional organizations and non-profit accrediting agencies developed standards for use by facilities for mentally retarded persons. Later, they were developed by regulatory agencies in which certification entitles the agency to review financial reimbursement. They have also been mandated by the courts.

Voluntary certification standards have been developed by the American Association on Mental Deficiency (AAMD), the Joint Commission on Accreditation of Hospitals (JCAH), and the Accreditation Council for services for Mentally Retarded and other Developmentally Disabled persons (ACMRDD).

Although AAMD, JCAH, and ACMRDD standards are viewed as three separate sets of distinct standards, the 1981 revision of ACMRDD represents an evolution from the original set of AAMD standards. Through this evolution, the philosophy regarding specifying ratios has significantly changed. Whereas, in the original AAMD standards, ratios for professional, nonprofessional, and support staff were specified, the JACH and ACMRDD standards primarily leave this determination to the professional judgment of the agency seeking accreditation.

Staffing standards have also been advanced by regulatory agencies. The most widely accepted standards of this type are those standards imposed by Title XIX of the Social Security Act and accompanying regulations. Like the ACMRDD regulations, the Title XIX standards do not specify professional staff ratios although Title XIX standards provide specific requirements for direct care staff. Each facility must

determine for itself the number of professional staff needed to deliver the type and level of care specified as needed by the facilities residents in accordance with stated goals and objectives. The financial incentives associated with these regulatory standards have helped to ensure participation by the majority of states in the Title XIX Program making these standards the most widely used standards in the United States. Schoerenberger found 94% of public residential facilities responding to his survey participated in the Title XIX Program. He found that of the 87,244 certified beds, 95% were ICF/MR while 5% were SNF.

Courts have also mandated specific staffing requirements. These standards have included both stated ratios by specific discipline and/or mandated overall staffing ratios.

Throughout the last decade, court litigation has been the most

dominate factor in shaping social policy regarding services to mentally retarded persons. Recognizing as it did that mentally retarded persons are entitled to protections under the Fourteenth Amendment, the courts ordered implemented minimally acceptable standards for facility operations. Staffing ratios were usually included in the ordered standards to ensure a minimum level of staff to provide mandated services.

An analysis of staff to resident ratios in public residential facilities serving the mentally retarded reveals decreases in the number of residents per employee and in increased allocations for the care and treatment of the mentally retarded, since the early 1950's. Butterfield surveyed the number of full-time employees per resident and the daily maintenance cost from the period of 1955 to 1970. In 1955 there was one full-time employee per 4.23 residents, while in 1971 there was one full-time employee per 1.52 residents. Actual figures reflect a work force

of approximately 34,000 in 1955 providing services to 143,548 residents as compared to 118,909 staff in 1971 providing services to 181,058 residents.

In a survey conducted 10 years later in 1982, Scheerenberger, again, found substantial increases in staff-to-resident ratios. He found an overall staff-to-resident ratio of 1.64 staff to 1 resident which represents approximately a 250% increase in the staff-to-resident ratios reported in 1971. These facilities reported an overall work force of approximately 195,130 employees providing services to approximately 118,982 residents.

Coleman, in a phone survey conducted in 1982, obtained results similar to those of Schreerenberger. Coleman's survey included 48 states since three states were unable to report comparable data. In reporting overall staff-to-resident ratio by state, Coleman found a

broad range of reported ratios. Oregon reported the lowest staff-to-resident ratio with .97 staff per resident while Massachusetts reported the highest staff-to-resident ratio with 2.99 staff per resident.

Coleman also reported staff-to-resident ratios per residential facility. This data included 205 facilities excluding those in Arizona, Connecticut, and Minnesota. Overall these ratios were 1.69:1. Again, a broad range of staff-to-resident ratios are reported with .66 staff to each resident at a facility in Mississippi to 3.82 staff to each resident at a facility in Massachusetts. Although overall ratios continue to increase at a national level, many residential facilities still maintain ratios significantly below the national average.

Scheerenberger in surveys over a 17 year period found that staffing ratios by category of staff also reflected substantial changes in both direct-care and professional staff-to-resident ratios. With regard to[2]

direct care, he reported staff-to-resident ratio of 1:4.4 in 1964, as compared to 1:.78 in 1980.

The number of professional staff has also increased substantially during the reported periods specified. These increases appear reflective of court mandates and ICF/MR regulations which emphasize active treatment. Medical staff have increased from 1:50 in 1964 to 1:12 in 1980. The number of educators increased from a ratio of 1:84 in 1964 to 1:14 in 1980. The number of therapists which includes recreational, occupational, physical, vocational and speech therapists has shown the most marked increase from 1:93 in 1964 to 1:15 in 1980. The number of social workers increased from 1:314 to 1:42 and psychologists from 1:501 to 1:60 during the reporting periods. Overall, there were 33 residents per professional support person in 1964 as compared to one to 5.25 in 1980.

As can be seen from preceding comments, although many systems rely on mandated staffing ratios, use of simple formulas in planning staffing needs are not sufficient to determine adequate staffing patterns. Other factors which are unique to each organization must be considered when developing and implementing a staffing plan. Both client and staff related factors must be considered. These include characteristics of the present and future residential population, predetermined program objectives, staff relief factors, staff vacancy factors, attrition rate, overtime rates, temporary employee rates, and reliance on contractual arrangements for staffing. One weakness in comparisons of staffing ratios such as those previously reported is that residential facilities are compared with regard to overall staffing ratios without consideration of other factors. Client characteristics such as level of functioning and/or physical and chronic medical conditions will greatly

effect comparability of these ratios. Additionally, staffing factors such as use of contractual services to operate complete service areas such as laundry, food services, housekeeping, and other auxiliary and support services will effect comparability. Consideration of services such as these are not typically reflected in the staff-to-resident ratios of the facilities and comparisons of ratios across facilities are not accurate, especially when complete service components are contracted for.

Although there has been a substantial increase in staffing ratios over the past two decades, there has been limited research concerning the beneficial effects of such increases on the residential population. It has been assumed that higher staffing ratios ultimately result in an increase in the quality of treatment and care provided. This finding has not been conclusively validated.

The following studies, although not meant to be inclusive are representative of studies which highlight factors effecting staff-to-resident interactions and in turn the quality of care provided. These factors when considered in conjunction with those aspects previously discussed concerning staffing ratios will facilitate both the development of a plan for manpower needs as well as staff deployment as related to client grouping.

While the lack of adequate staff-to-resident interaction is often attributed to insufficient staff coverage, Harris, Veit, Allen, and Chinsky (1974) found that this was not necessarily the case. They studied the effects of decreases in staffing ratios and/or in ward population density on aid behavior towards residents.

In their first analysis, they increased group density by increasing the number of residents in the group while holding the staffing ratios

constant. They found the total time staff spent interacting or the proportion of various types of interaction other than formal training which was consistently less frequent in the high density group, did not significantly change when a second aide and a corresponding number of residents joined the group.

Secondly, they studied changes in staffing ratios when population density of the ward was held constant. Using two levels of staff-to-resident ratios, a high ratio of residents to staff when one aide was present or a low ratio when two staff were present, they found introduction of a second aide did not effect resident care significantly as provided by either aide, although the number of residents each were responsible for was lowered significantly. Instead, each aide tended to maintain the level of interaction that they typically provided.

Balla, Butterfield, and Zigler (1974) examined characteristics of

the institution to determine effects on responsiveness to social reinforcement, MA, IQ, verbal dependency, extent of imitation of adults, and variability of resident behavior. They examined characteristics of the institutional setting such as size, number of residents per living unit, cost per resident per day, employee turnover, number of direct care and professional staff per resident, and volunteer hours per resident per year.

The four institutions studied ranged in size from 400 to 2,000 residents and substantially varied with regard to cost, aide to resident ratios, and employee-turnover rate. Residents were studied at six months after admission and again at 2.5 years after admission. Results indicated that residents in the largest of the four institutions were more responsive to social reinforcement, however, none of the other characteristics of these facilities were found to be related to changes

in resident behavior or characteristics.

McCormick, Balla, and Zigler (1975) investigated resident care practices in 30 institutions through the United States and in a Scandinavian country. An investigation of care practices in types of institutions reflected that the most resident oriented care practices were found in group homes although there were less aides and professional staff per resident, while large institutions reflected the most institutionally-oriented care practices which were characterized by rigidity of routine, regimentation of residents, depersonalization, and limited interaction between staff and residents. Large regional centers reflected care practices which were between these two extremes. The ratio of direct care staff to residents, the number of professional staff to residents, employee turnover, or cost had little effect on the type of care provided.

The number of residents per living unit and the level of retardation of the residential population additionally effected care practices. Institutional-oriented care practices were observed when the number of residents per living unit were greater and on living units housing more severely retarded individuals. The authors suggest that creating smaller, less populated living units and assigning staff to specific residents may create a more resident-oriented environment.

In another study, Moores and Grant (1977) studied the effects of varying staffing levels in facilities for the mentally retarded on Adaptive Behavior Scale Scores, frequency of various types of staff-resident interactions, and adaptive versus maladaptive behavior activities. The staff-to-resident ratio was approximately 50% higher at one residential facility versus the other.

It was found that although staff-to-resident ratios significantly

differed in these facilities, this did not result in significantly different adaptive behavior scores. Moores and Grant concluded, "a major implication of this study is that the investment of more manpower in institutional programs appears not to affect appreciably the adaptive behavior level of retarded adults. This, in itself, raises a number of important issues concerning staffing policy."

Additionally, it was found that resident characteristics effect staff interactions regardless of staffing ratios. Residents who exhibited higher assessed levels of independence received a higher proportion of the staff-resident interactions. The authors suggest specific staff-resident assignments to counter this trend towards staff exclusion of interactions towards less attractive, more handicapped residents. This finding was also noted by Dailey, Allen, Chinsky, and Veit (1974).

When the staff-to-resident ratio is increased, those clients who are viewed more positively by staff still receive disproportionally more attention than less positively viewed residents.

Raynes (1980) also found that grouping of residents by functional ability also has a negative impact on care-giving practices.

He found that the less competent the ward population, the more institutionally oriented are the care practices and the greater the staff-resident social distance maintained. Those who were less competent were also spoken to with less informative and more controlling speech. The nature of the physical environment was also more barren and lacking of physical amenities in areas housing less competent individuals. Raynes further pointed out that staff must also work in these barren, less stimulating environments if assigned to groups of less competent residents, therefore, it may be hypothesized

that staff will tend to be less content which in turn may effect the services which they provide.

Raynes, concludes, "what is clear now, is that for severely mentally retarded individuals, homogeneous functionally based groupings appear to generate an environment in which direct-care staff consistently provide care which is characteristically unstimulating, undifferentiated, depersonalized, and rigid. Efforts to change this have to involve altering policies. New policies must reflect a philosophy not of separate and worse for some, but a more positive approach to the use of available resources both physical and human, to meet the needs of all the resident population."

Blindert (1975) observed and classified staff-resident interactions in a study of 15 children and 17 attendants who were their primary care providers. During the observation periods, an average

of 2.4 staff and 7.6 residents were present. Results indicated that in a 10 minute observation period, 14.8 interactions between staff and residents occurred, or an average of 1.94 interactions per resident, and interactions between attendant to attendant average 7.8 interactions of which 4.6 were not resident related. Blindert concludes, "an increase in the number of staff in a situation signifies an increase in the number of interactions between staff on a topic not related to the clients rather than an increase in learning and teaching activities."

CONCLUSIONS:

In summary, two major conclusions emerged from this review.

First, after almost a century of massive neglect, denial, and rejection, a more optimistic view of mentally retarded persons and their abilities have emerged. This has resulted in social action

programs which have significantly improved the plight of mentally retarded persons residing in both community and in public residential facilities. Emphasis on more humane treatment and care by the general public has resulted in a substantial increase in per diems which reached a national average of over 30,000 per year in 1983 with corresponding increases in staffing ratios. These ratios have increased from a staff-to-resident ratio of .24:1 in 1955 to approximately 1.69:1 in 1983.

Secondly, although we have seen an unparalleled growth in services for mentally retarded persons and corresponding increases in staffing ratios, there have been few empirical studies validating the cost/benefit relationship regarding these increases. Further research is needed to identify staff related, resident related, and environmental factors which may contribute to variations in the

quality of care provided as a function of this increased staffing. Factors such a resident groupings, resident characteristics, staff density, facility size, staff training, environmental factors, etc., must be investigated in conjunction with staff increases. While in the previous decade public sentiment led to a rallying for services for the mentally retarded, there presently appears to be considerable pressure at the national, state, and local levels to maintain the present standard of treatment and care while more efficiently utilizing existing resources, including staff, to counter spiraling costs. With the general public and our elected officials no longer content to increase all ratios based on sentiment of historical neglect, empirical data will be needed in the future to substantiate requests for increased allocations and corresponding staff increases.